OBSERVE, REPORT, AND RECORD

INSIGHTS FOR THE SUPPORT STAFF

Revision June 10 2010

OBSERVE-TO GUARD, WATCH, OR TAKE NOTE OF

- In your role as direct care staff, you have a responsibility to observe what is happening with the consumers under your care.
- As you observe, you are responsible for reporting to your supervisors those areas that you note are out of the ordinary or otherwise unusual for the consumer.

REVIEW OF BODY SYSTEMS

- Musculoskeletal
- Nervous
- Sensory
- Cardiovascular
- Respiratory
- Digestive
- Urinary
- Reproductive
- Endocrine
- Integumentary
- Lymphatic

MUSCULOSKELETAL SYSTEM

- Fractures
- Arthritis
- Contractures
- Sprains/Strains

WHAT TO REPORT

- Muscle weakness
- Joints with swelling
- Loss of balance
- Increase in falls

OBSERVE/REPORT

OBSERVE/REPORT

NERVOUS SYSTEM

Strokes

Spinal Cord Injuries

Multiple Sclerosis

Seizure Disorder

Parkinson's Disease

Organic Brain Syndrome

WHAT TO REPORT

- Severe headaches
- Sleep disturbances
- Loss of thinking ability
- Increased forgetfulness

SENSORY

- Cataracts, glaucoma
- Hearing loss
- Taste of food changes

WHAT TO REPORT

- Pain in the eye
- Drainage from eyes, ears, or nose
- Hearing loss
- Difficulty with speech

OBSERVE/REPORT

OBSERVE/REPORT

RESPIRATORY SYSTEM

- Emphysema
- Cancer
- Tuberculosis
- Pneumonia
- Asthma
- Allergies

WHAT TO REPORT

- Shortness of breath
- Respirations under 12 or over 22
- Persistent cough or coughing up blood
- Shallow breathing

CARDIOVASCULAR SYSTEM

Coronary Artery Disease

Congestive Heart Failure

Hypertension

Irregular heart beat

Heart murmur

Blood clots

WHAT TO REPORT

- Chest pain or pressure
- Shortness of breath
- Swelling around ankles, hands, and feet
- Lips, fingernail beds, or feet turning blue

OBSERVE/REPORT

OBSERVE/REPORT

DIGESTIVE SYSTEM

- Constipation
- Diarrhea/Vomiting
- Ulcers
- Gastritis
- GERD/Reflux
- Coughing with food intake/Aspiration
- Hemorrhoids

WHAT TO REPORT

- Constipation or diarrhea, that persists
- Unusually bad breath
- Bleeding from mouth or rectum
- Distended/swollen abdomen
- Difficulty in swallowing
- Abdominal discomfort

URINARY SYSTEM

- Urinary Tract Infections
- Enlargement of prostate
- Sexually Transmitted Diseases (STD's)
- Incontinence

WHAT TO REPORT

- Inability to pass urine
- Painful or burning urination
- Discolored or foul smelling urine

OBSERVE/REPORT

OBSERVE/REPORT

REPRODUCTIVE SYSTEM

- Prostate Cancer
- STD's
- Uterine/Ovarian Cancer
- Painful menstruation
- Vaginal Infections
- Pregnancy

WHAT TO REPORT

- Vaginal itching
- Unusual or heavy bleeding
- Foul odors or discharges
- Skin breakdown on scrotum or penis

ENDOCRINE SYSTEM

- Diabetes
- Hyperthyroidism
- Hypothyroid
- Growth Disorders

WHAT TO REPORT

- Gain or loss of 5# over past month
- Excessive hunger, thirst, and urination
- Fatigue
- Tingling in hands
- Sensitivity to the cold

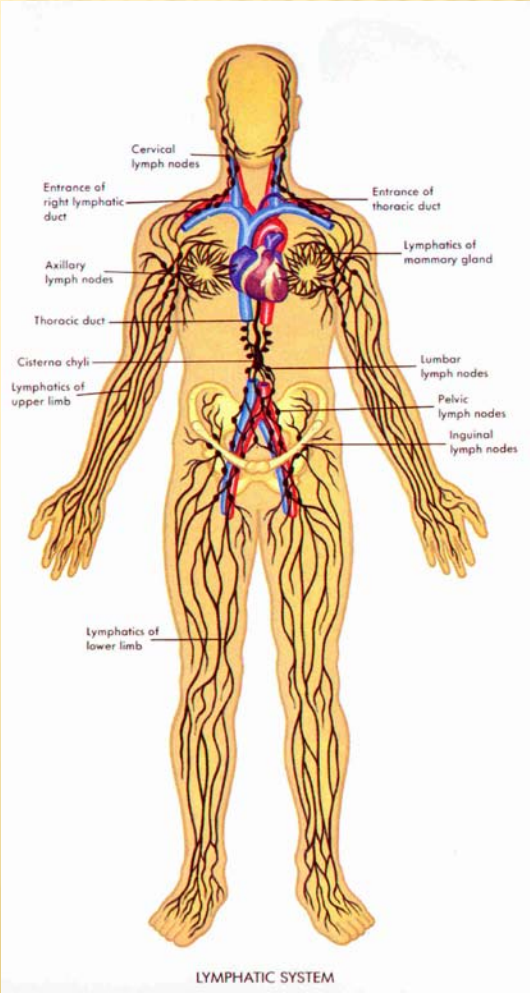
OBSERVE/REPORT

OBSERVE/REPORT

LYMPHATIC SYSTEM

WHAT TO REPORT

- Pain in lymph node area
- Enlarged nodes
- Extreme fatigue
- Extreme weakness



INTEGUMENTARY SYSTEM

- Dry or oily skin
- Shingles
- Herpes
- Poison Ivy
- Lice
- Brittle finger nails
- Skin tears/ulcers
- Boils, cuts, bruises
- Hair thinning

WHAT TO REPORT

- Any change in skin color
- Itching
- Tears or bruises on the skin
- Loss of hair
- Change in the finger and toe nails
- Boils that have pus

OBSERVE/REPORT

REVIEW OF BODY SYSTEMS

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FACTORS IN REPORTING

- As a direct care or support staff, you have the responsibility to report the changes or concerns that you observe.
- Reporting can be verbal and it can be in writing, this we will refer to as ‘documentation.’
- Each agency will have protocols to follow for reporting.

OBSERVE AND REPORT THE INFORMATION

Subjective information vs. Objective information

OBJECTIVE INFORMATION

- Objective information is factual.
- It is what you observe: what you see, hear, touch, smell.
- It is measureable

SUBJECTIVE INFORMATION

- Subjective information is related to a person's experiences
- It is related to ones knowledge about something or someone.
- It is information given to you by someone else.

INFORMATION-OBJECTIVE OR SUBJECTIVE

THIS IS JACOB

THIS IS KATELYN

WHAT DO YOU OBSERVE

DOCUMENTATION

The Webster's Dictionary says…

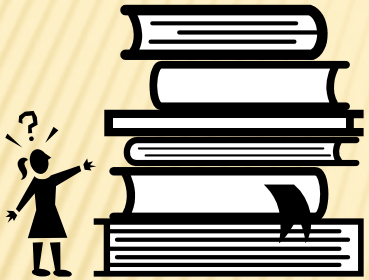
Providing factual support for statements made

Taber's Medical Dictionary says…

Recording pertinent information concerning a patient.

RECORDING OR WRITING LOGS, CASE NOTES, DAILY NOTES, CHARTING, LOGGING.

CODE OF STATE REGULATION MEDICAID WAIVER



- CODE OF STATE REGULATIONS, 13 CSR 70-3.030, SECTION (A)
- ADEQUATE DOCUMENTATION
- MEDICAID WAIVER REQUIREMENTS

RECORDING IN THE CONSUMER RECORD

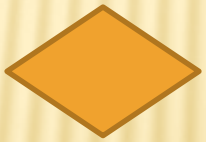
DOCUMENTATION IN THE RECORD:

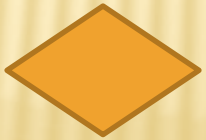
- PROVIDES CONTINUITY OF CARE
  - Treatment planning
  - Personal plan effectiveness
- ACCOUNTABILITY
  - States the services that are provided
  - States how the individual is being supported

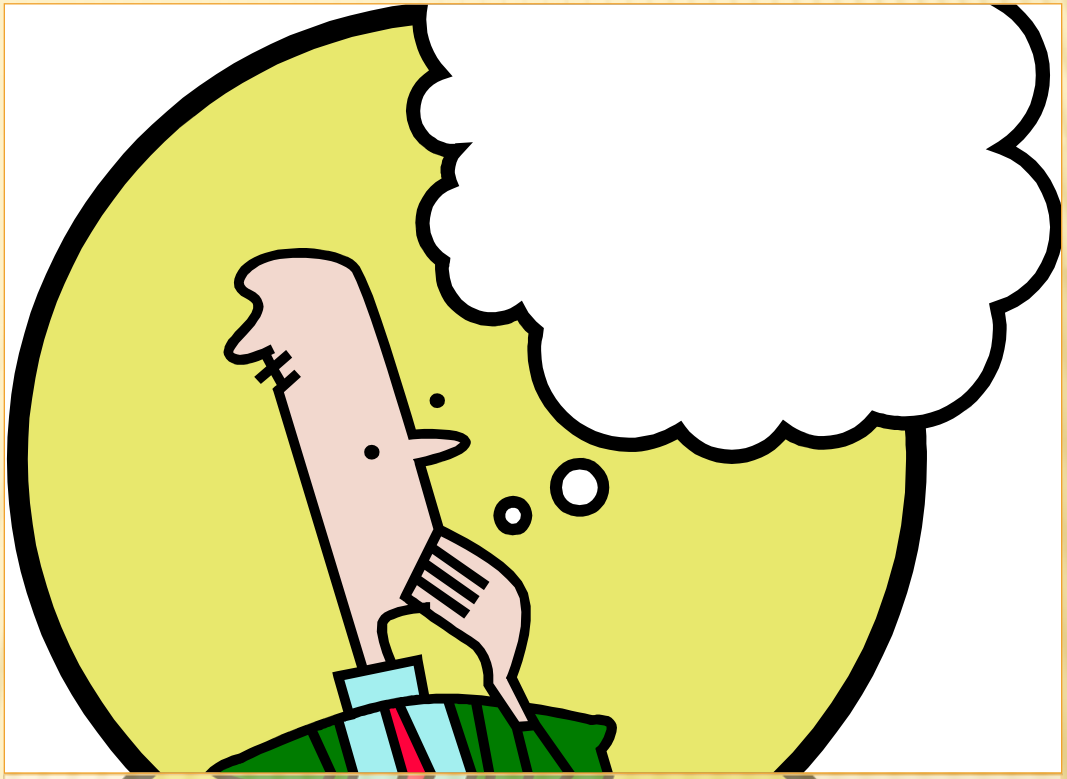
THE MEDICAL RECORD IS A LEGAL DOCUMENT

What is written today may become a matter of court record tomorrow, next month or years down the road.

Your documentation needs CLEAR and PRECISE TERMS what actually happened, using language that is:

Factual  Accurate

Subjective  Objective



THINK TANK

"Zach threw a fit today. He made a fool of himself in front of everyone at Pizza Hut.

EXERCISE 1

- This is Timothy

EXERCISE 2

- This is Amelia

KEY WORDS:
"FACTUAL AND PERTINENT"

ACCURATE STATEMENTS

ACCURATE NOTE

- I entered the room and found Sam lying on the floor. He was jerking his arms and legs. This lasted about 20 seconds. I noticed redness on his forehead.

OPINIONATED NOTE

- I entered the room and found Sam having seizures. He must have bumped his head when he fell because there was a mark on the side of his head.

POINTS TO REMEMBER

- Keep your attitude in check. Stop and think for a moment before you write about a situation, especially if you are upset by it.
- Think about what is pertinent and factual.
- Check that you have the correct chart before you begin writing.
- Each encounter with the client must contain the date of contact and be signed by the staff.
- Think who, what, where, when, why, and how.

DOCUMENTATION BASIC PRINCIPLES

- Every page needs to include the consumer's name.
- Use black ink-no pencils
- Recording should be clear, concise and legible.

DOCUMENTATION BASIC PRINCIPLES

- Only recognized abbreviations should be used in the recording.
- Use correct grammar and spelling.
- Date, time, and sign each entry.

DOCUMENTATION BASIC PRINCIPLES

- Document and draw a line to the end of the paper, then sign your name.
- If you make an error-line it and initial it!
- White-out is illegal - do not use it.

THE DON'TS OF CHARTING

- Don't chart a symptom without stating what you did about it.
- Don't alter a medical record-this is a criminal offense.
- Don't chart ahead of time-charting care you have not done is fraud.
- Don't chart what someone else said unless you quote the information given with the source.
- Don't name a second consumer…doing so violates that consumer's confidentiality. If you have to refer to a second consumer, do so by using terms like "room mate" or "housemate".

BIBLIOGRAPHY

- A SURVIVAL GUIDE TO DOCUMENTATION INVESTIGATIONS TRAINING-Victor Stoddard
- CODE OF STATE REGULATIONS
- DDD MEDICAID WAIVER MANUAL
- MO HealthNet Division
- DOCUMENTATION ISSUES - Lorman Education Services
- LEVEL ONE MEDICATION AIDE GUIDE-INSTRUCTIONAL MATERIAL LAB-UMC
- MEDI-SMART NURSING EDUCATION RESOURCES
- TABER'S CYCLOPEDIC MEDICAL DICTIONARY

QUESTIONS?

This training was prepared to help Direct Care Staff become more confident with the responsibilities in safeguarding the health and safety of the consumers.